U. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 8 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

5595

State File No.

Registration District No. 42 Primary Registration District No. 1800 Registrar's No. 166

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 1/2 months (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2916 Penn St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Asel Lamar
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Mrs Asel Lamar
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased Aug (Month) 11 (Day) 1874 (Year)

8. AGE: Years 70 Months 6 Days 1 If less than one day hr. min.

9. Birthplace Indiana (City, town, or county) (State or foreign country)
10. Usual occupation RR Engineer
11. Industry or business RR
FATHER
12. Name Abel Lamar
13. Birthplace Tenn (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name James White
15. Birthplace N.C. (City, town, or county) (State or foreign country)
16. (a) Informant Hosp Records
(b) Address St Joseph Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Wichita, Kansas
18. (a) Signature of funeral director H. O. Siderfaden
(b) Address St Joseph Mo
19. (a) 2-12-45 (Date received local registrar) (b) Allan J. Fickel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12 year 1945 hour 6 minute 42 A.M.
21. I hereby certify that I attended the deceased from Apr 6, 1944 to Feb 12, 1945 that I last saw him alive on Feb 11, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic bronchopneumonia — Duration
Due to
Due to
Other conditions Chronic colitis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature E H McGee (M. D. or other) MD
Address State Hosp #2 Date signed 2-12-45

1377

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Keith Collier

Licensed Embalmer No. 3632

P. O. Address St Joseph M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.